Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 8 December – Friday, 12 December 2025
Tuesday, 23 December 2025
Friday, 6 February 2026
Tuesday, 7 April – Thursday, 9 April 2026
Wednesday, 9 September 2026

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

and

Virtual Hearing

Name of Registrant:	**Susan Sanni**
NMC PIN:	07H2082E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – 29 September 2007
Relevant Location:	Luton
Type of case:	Misconduct
Panel members:	Judith Webb (Chair, Lay Member) Jessica Read (Registrant Member) Joanna Bower (Lay Member)
Legal Assessor:	John Bassett (8-12 December 2025) Angus Macpherson (6 February 2026) Jayne Wheat (7-9 April; 9 September 2026)
Hearings Coordinator:	Angela Nkansa-Dwamena Sharmilla Nanan (6 February 2026)
Nursing and Midwifery Council:	Represented by Sally Denholm, Case Presenter
Mrs Sanni:	Present and represented by Christopher Bealey, Counsel instructed by Thompsons Solicitors.
Facts proved by admission:	Charges 1a and 1b (as amended)

Facts proved:	Charges 1c, 2a and 2b(i)
Facts not proved:	Charge 2b (ii)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge (original)

That you, a registered nurse, whilst working at St Marys Nursing Home:

1. On 14 July 2022:
    a. Signed one or more resident's repositioning charts that had been completed in advance by care staff.
    b. Signed one or more resident's daily notes that had been completed in advance by care staff.
    c. Slept whilst on duty

2. Your conduct at charges 1a and/or 1b was dishonest in that you:
    a. Signed residents records that contained incorrect information
    b. Knew care staff:
        i. Had not repositioned one or more residents
        ii. Had not conducted hourly checks on one or more residents

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Background

On 18 January 2023, the Nursing and Midwifery Council (NMC), received a referral from BUPA, raising concerns about you. The charges arose whilst you were working as a registered nurse at St Mary's Nursing Home (the Home).

It is reported that on the night shift of 13/14 July 2022, the interim Manager of the Home, along with a senior care assistant, undertook an unannounced visit. It is alleged that just after 02:30 hours, you were found in the tearoom, a communal area, on a resident's recliner chair in the dark with blankets and cushions on you. You denied being asleep and you said that you were resting your eyes and legs.

The interim Manager also reported that she had found that all room folders had been removed from residents' bedrooms, collected together and were found on a linen trolley near the nurse's station. The repositioning charts had been pre-filled from 02:30 hours to 03:00 hours and again for 06:30 hours. Four residents were checked, and it is said that they had not been repositioned, despite the charts being completed to say they had. It is further alleged that you had also signed the daily notes which had been pre-filled in advance.

A local investigation was conducted, and you were dismissed from your role at a disciplinary hearing on 6 September 2022.

Decision and reasons on application for hearing to be held in private

Prior to giving your evidence, Mr Bealey, on your behalf, made an application for parts of this hearing to be held in private. This is on the basis that proper exploration of your case involves references to your [PRIVATE]. This application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Denholm, on behalf of the NMC, indicated that she supported this application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there may be references to your [PRIVATE], the panel determined to hold these matters in private as and when such issues are raised in order to protect your privacy.

Decision and reasons on application to amend the charge

During its deliberations and in considering the evidence as a whole, particularly your oral evidence, the panel was concerned about whether your admission, at the commencement of the hearing, to Charge 1b, as originally drafted had been correctly made. The panel noted that Charge 1b, as drafted, is worded as:

1. On 14 July 2022:
    b. Signed one or more resident's daily notes that had been completed in advance by care staff.

Given your oral evidence that you were responsible for completing the relevant entries in the daily notes, as evidenced in the documentary evidence before the panel, the panel was minded to amend Charge 1b to remove 'by care staff'. The panel heard the advice of the legal assessor, who referred to Rule 28 (1) of the Rules, which states that amendments to a charge can be made prior to a panel's determination of the facts. The legal assessor also referred the panel to the cases of *The King (on the application of the Chief Constable of West Midlands Police) v Police Misconduct Panel (Srivastra - Interested Party)* [2022] EWHC 3076 (Admin) and *PSA v Health and Care Professions Council and Doree* [2017] EWCA Civ 319 and the cases referred to therein, including *PSA v NMC and Jozi* [2015] EWHC 764 (Admin).

The panel wished to hear representations from both parties, recognising that if the charge was so amended, you would once again be asked if you admitted to this charge as amended.

Ms Denholm indicated that she supported the proposed amendment suggested by the panel, as it would accurately reflect the evidence. She submitted that you have already accepted that you were the one who made the entries in the residents' daily notes and that the mischief of the charge namely, completing resident records in advance, would not cause any unfairness to you and does not substantially differ from the allegations made at the outset.

Mr Bealey submitted that he had no objections to the proposed amendment, as it accords with the admission that you had intended to make. He submitted that the account you have given has always been the same, in that you were the one who made the entries in the residents' files, not the care staff. He submitted that the mischief of the charge remains the same and it would better reflect the evidence before the panel.

The panel made the following amendment:

Original Charge

That you, a registered nurse, whilst working at St Marys Nursing Home:

1. On 14 July 2022:

    b. Signed one or more resident's daily notes that had been completed in advance by care staff.

Proposed Amendment

That you, a registered nurse, whilst working at St Marys Nursing Home:

1. On 14 July 2022:

    b. Signed one or more resident's daily notes that had been completed in advance ~~by care staff~~.

The panel was of the view that such an amendment was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being made.

Details of charge (as amended)

That you, a registered nurse, whilst working at St Marys Nursing Home:

1. On 14 July 2022:
    a. Signed one or more resident's repositioning charts that had been completed in advance by care staff. **(ADMITTED)**
    b. Signed one or more resident's daily notes that had been completed in advance. **(ADMITTED)**
    c. Slept whilst on duty. **(DENIED)**

2. Your conduct at charges 1a and/or 1b was dishonest in that you:
    a. Signed residents records that contained incorrect information **(DENIED)**
    b. Knew care staff:
        i. Had not repositioned one or more residents **(DENIED)**
        ii. Had not conducted hourly checks on one or more residents **(DENIED)**

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Bealey, who informed the panel that you made a full admission to Charge 1a. Following the amendment of Charge 1b, Mr Bealey informed the panel that you also make a full admission to Charge 1b, as amended.

The panel therefore finds Charges 1a and 1b proved in their entirety, by way of your admission.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Denholm and Mr Bealey.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Sandra Do Carmo Miranda: Interim Manager at the Home at the time of the incident.
- Sue Green: Registered Care Home Manager and Internal Investigator for the incident.
- Sharon Clayton: Senior Care Assistant at the Home at the time of the incident.

The panel also heard evidence from you under oath.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mr Bealey.

The panel then considered each of the disputed charges and made the following findings.

Charge 1c

1. On 14 July 2022:

…

c. Slept whilst on duty

This charge is found proved.

In reaching its decision, the panel took into account the oral and documentary evidence of Sandra Do Carmo Miranda (Ms Do Carmo Miranda) and Sharon Clayton (Ms Clayton) and your oral and documentary evidence.

Ms Do Carmo Miranda, within her NMC witness statement dated 20 March 2024, stated:

> *'I conducted an exit interview with* [Colleague A] *which is part of the company policy. This night nurse advised me the reason that she was leaving is that staff nurses and care assistants were sleeping on duty, and she provided me with the staff names, one of these was SS.*
>
> *…*
>
> *I conducted this unannounced visit with a witness senior carer [Ms Clayton].*
>
> *…*
>
> *I found the two carers sleeping with the beds made up the same as the ones that I had seen on the first floor. The carers were called* [Carer 1] *and* [Carer 2]*. I walked down the corridor to the nurses' station to locate SS and I couldn't find her. We have a little tearoom called Olive Café tearoom which is opposite room 25 and I noted that the door was closed and the lights were off; there should have been night lights illuminated. In the communal areas you need to*

maintain night lights only. They are little lights located on the wall so the residents can sleep. This was around 02:40am. I opened the tearoom door and went in with SC and I turned the lights on, I saw SS she looked startled and disoriented like she had just woken up. She said, 'what's going on?' I took a photograph of her which has been provided to the NMC, this shows the position that she was in when I found her in the chairs. She is awake in this photograph and smiling which I found concerning given the seriousness of the situation. I recognised the reclining chair as one belonging to a resident in room 26.'

This account was supported by Ms Do Carmo Miranda's oral evidence and the oral and documentary evidence of Ms Clayton.

Ms Do Carmo Miranda further stated in her witness statement:

'…I did not see her with her eyes closed at any point, I am not able to definitively say that she was sleeping, but to me she looked like she had just been woken up even though her eyes were open…'

During cross examination, both Ms Do Carmo Miranda and Ms Clayton accepted that they had not seen you with your eyes closed but they assumed that you had been asleep or had intended to fall asleep given your presentation and the fact that you were found in a darkened room, with the door closed. Ms Do Carmo Miranda also accepted that there may have been a level of unconscious bias considering the fact that she and Ms Clayton had already found other members of staff sleeping within the Home. The panel considered that Ms Do Carmo Miranda's ability to admit a limitation in her account made her a more credible and reliable witness as she did not seek to overstate the certainty of her account.

You told the panel that during a 'quiet period' and following the completion of some of your duties, you decided to go and 'rest'. You explained that you needed to rest your leg as you were experiencing [PRIVATE] and that you had retreated to the

Olive Café at around 02:08 hours as the chairs at the nursing station were uncomfortable.

You admitted that you were not supposed to take a reclining chair from a resident's room, and this fact has not been challenged. You said you placed a sheet over the reclining chair as a barrier and placed a jacket over your leg, as it requires [PRIVATE]. You said that the reason for turning off the main lights was that the reflection would have disturbed the resident who was across the corridor. But you stated that you had the side light in the room on. You asserted that you were not asleep and could not have slept as you were the sole nurse on duty and needed to be alert for any potential call buzzers. You further stated that at 03:00 hours, you were due to take another resident out for a smoke therefore, you were in the café for a 'rest' as you could not take an official 'break'. You said that you were unaware that other staff were sleeping at the same time.

However, during an investigation interview with Sue Green (Ms Green) on 22 July 2022, you stated that it was a hot day and that you had opened a window and turned the lights off to cool down the Home. You further reiterated this during your disciplinary meeting on 6 September 2022:

> *'On that day, that month, it was very hot. The coffee room I went into around 02:08am, I switched off the lights to cool the room down, I switched off corridor lights to cool the home down. Lights were switched off to cool the place down.'*

During cross examination, when this matter was put to you, you could not reconcile the inconsistency in your account.

The panel considered the above evidence and accepted the evidence of Ms Do Carmo Miranda and Ms Clayton. The panel acknowledged that while there is no direct evidence from Ms Do Carmo Miranda and Ms Clayton that you were observed to have been asleep, the surrounding circumstances strongly supported this conclusion. Firstly, the panel noted that the unannounced visit occurred following a

report from a departing member of staff, Colleague A, stating that night staff were sleeping on duty. Secondly, you were found in a darkened room, lying on a reclining chair that had been removed from a resident's room. The chair was covered with a sheet, and your legs were draped with your jacket, giving the appearance of someone preparing to sleep. In your local statement, which you wrote on the day in question, you stated that you were 'resting your eyes'.

The panel considered your evidence very carefully. In doing so, it bore in mind that, prior to the incident, you had an unblemished record and had been employed by BUPA since 2011. It recognised that your previous good character was something that potentially gave credibility to your evidence and illustrated that you did not have the propensity to act as alleged.

However, the panel found that your explanation with regards to why the lights were turned off was inconsistent and you were unable to reconcile this discrepancy during cross examination. The panel accepted that you have denied sleeping throughout the local and regulatory investigations. However, improperly moving the reclining chair from a resident's room and the manner in which you had set it up in the Olive Café was more consistent with you preparing to sleep rather than to just rest your eyes or leg. In this regard, the panel considered it to be of note that, when interviewed by Ms Green on 22 July 2022, you said:

> *'I did not know the boss was in the building otherwise I would never have sat in the recliner chair and made myself comfortable …'*

The panel also considered that you would have been aware that sleeping on duty was contrary to BUPA's policy and could result in an adverse outcome and, therefore, limited weight could be attached to the consistency of your denial.

In the wider context, the panel considered that other carers were also found asleep on both floors of the Home at the time, indicating that sleeping on duty was an accepted practice within the workplace, as suggested by Colleague A. In the circumstances, the panel considered it to be implausible that you were merely

resting your legs and eyes while, unknown to you, those other carers (two of whom were supervised by you) were asleep in nearby rooms.

In these circumstances, the panel was satisfied that it is more likely than not that you were asleep whilst on duty.

Accordingly, the panel found Charge 1c proved.

Charge 2a

2. Your conduct at charges 1a and/or 1b was dishonest in that you:
    a. Signed residents records that contained incorrect information

This charge is found proved.

In reaching this decision, the panel considered your admissions to Charges 1a and 1b. The panel also had regard to the repositioning charts and the residents' daily notes. The panel considered that the term 'residents [sic] records' encompasses both the repositioning charts and the daily notes.

The panel noted that you accepted that it was your signature on the repositioning charts (Exhibit 3, p. 24, 25 and 26) and the residents' daily notes before the panel. You explained that the repositioning documentation is undertaken by care staff and that your only responsibility is to countersign the document. With respect to the daily notes, you told the panel that it was solely your responsibility to complete this documentation and that the relevant entries on the daily notes before the panel (Exhibit 3, p. 28, 29 and 30) were completed, timed and signed by you.

Ms Do Carmo Miranda told the panel, and it accepts, that she and Ms Clayton entered the Home at around 02:30 hours on 14 July 2022. You told the panel that you had gone to the Olive Café at 02:08 hours, where Ms Do Carmo Miranda and Ms Clayton found you, on 14 July 2022. In these circumstances, it is plain that the relevant entries you made on Exhibit 3, p. 28, 29 and 30 and your countersignature

on Exhibit 3, p. 25 were made before the times shown on those entries. The panel was unable to discern the purported timings of the entries on Exhibit 3, p. 26 and the entries on Exhibit 3, p. 24 all purported to have been made on 13 July 2023.

The NMC's case is essentially that, in making the relevant entries on the daily notes and by countersigning the repositioning chart, you were acting dishonestly. You intended that anyone subsequently examining the records would believe the entries and the countersignature had been made at the time shown in those documents.

Always bearing in mind that the burden of proving you acted dishonestly remained on the NMC throughout, the panel considered whether there was a reasonable alternative explanation for your actions.

With respect to the repositioning chart, you told the panel that a carer had handed you the chart to countersign and that you were under the impression that you were signing for the repositionings up to the hour of 02:00. You said that you were not paying attention to the timing on the document and were unaware that it stated 02:45 hours.

In relation to the daily notes, you accepted that you had made the entries and signed the daily notes in advance. However, you said that this was done following instructions from the Home Manager (who at the time of the incident was on sabbatical leave), given approximately a week prior to the incident, following a recent Care Quality Commission (CQC) inspection, that you should 'spread the time' of your documentation. You also told the panel that, were anything of note to happen to any of the residents after you had made the entries, you would have subsequently added that information to the daily notes.

In considering your explanations, the panel noted that you had worked with BUPA for approximately 11 years and you have been a registered nurse since 2007. The panel was of the view that in light of your experience, you would have been fully aware of the requirements of the Code regarding the accuracy of record keeping, as well as BUPA's policy on record keeping. The panel considered that accurate record keeping

is a fundamental responsibility of a registered nurse, and the panel was satisfied that you would have been aware of both the organisational policy and the professional expectations placed upon you.

In relation to your countersigning the repositioning chart, the panel noted that when interviewed by Ms Green on 22 July 2022, rather than saying you did not see the time that had been entered, you stated:

> *'*[Ms Green]: *So, the carer has falsified this record and is saying they have repositioned this resident, but they haven't?*
>
> [You]: *I should not have signed this, and I put my hands up. They are good workers."*
>
> *…..*
>
> *'*[Ms Green]: *Except on your watch as a nurse you have allowed the carers to prewrite the notes and sign paperwork*
>
> [You]: *Yes, and I shouldn't have.'* [sic]

Had you simply failed to note the timing of the entry in the repositioning chart, the panel would have expected you to have told Ms Green when she interviewed you. In the circumstances, the panel cannot accept the explanation you gave in your evidence and finds that the account you gave Ms Green was a true account. As such, it is satisfied on a balance of probabilities that when you countersigned the repositioning chart, you were aware that the entry had been timed at 02:45 hours.

In relation to the daily notes, the panel did not consider your explanation to be a credible account. If you had been told by the Home Manager to 'spread the time' of your documentation, it would reasonably have been expected that you would have raised it at the time of the incident when you made your initial statement (Exhibit 3, p. 10 and 11), during your meeting with Ms Green, or within your reflection dated 26 April 2024 or at least in your recent witness statement dated 10 December 2025.

However, this explanation was brought forward for the first time during your oral evidence.

The panel also considered your suggestion that, were anything of note to happen to any of the residents after you had made the entries you would have subsequently added the information to the daily notes, to be implausible. The panel noted that the relevant entries were effectively in identical terms, each containing the phrases: *"Settled for the night ….Safety checks maintained. Slept … well".* The panel was in no doubt that the entries had been written in advance of you and the carers going to sleep while on duty and in such a way as to suggest to anyone who read the notes subsequently that the residents had been checked regularly and had had an incident free night.

Having rejected your accounts, the panel went on to consider whether your admitted actions in Charges 1a and/or 1b were dishonest. It had regard to the test set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67*,* which outlines the following*:*

- What was the defendant's actual state of knowledge or belief as to the facts; and
- Was the conduct dishonest by the standards of ordinary decent people?

For the reasons already stated, the panel was satisfied on a balance of probabilities that you countersigned the repositioning chart and made the relevant entries in the daily notes knowing that they contained incorrect information and that you did so in order to mislead anyone who subsequently examined the notes into believing that the residents had, in the early hours of 14 July 2022, been provided with their expected care. The panel was of the view that you had the responsibility to ensure that residents' records were accurate.

The panel concluded that your actions would also be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charge 2a proved.

Charge 2b(i)

2. Your conduct at charges 1a and/or 1b was dishonest in that you:

    …

    b. Knew care staff:

        i. Had not repositioned one or more residents

This charge is found proved.

In reaching its decision, the panel again considered your admission to Charges 1a, as well as its findings in relation to Charge 2a. The panel also took into account the oral and documentary evidence of Ms Do Carmo Miranda and your oral and documentary evidence. The panel recognised that, in order to find this charge proved, it had to be satisfied that, when you countersigned the repositioning chart (Exhibit 3, p.25), you knew that the resident had not been repositioned.

The panel accepted the unchallenged evidence of Ms Do Carmo Miranda, that the resident repositionings had not been undertaken on 14 July 2022:

> *'The repositioning charts had been pre-filled from 2.30am to 3am and again for 6.30am. Four residents were checked, and they had not been repositioned, despite the charts being completed to say they had. One of the care staff involved confirmed that they had not been repositioned. When asked, SS said she had signed the charts without checking the times. SS admitted to signing the repositioning charts knowing that the care staff had falsified the record.'*

When asked how you would have satisfied yourself that the repositionings had in fact been carried out, your response did not directly address the question. You told the panel that even if the timings of entries in the repositioning charts were incorrect, you

trusted that the carers either had undertaken or would undertake the repositioning of residents. As such, when you countersigned the repositioning chart (Exhibit 3, p.25), you did not know that the resident had not been repositioned at the required time.

In considering whether the NMC has proved this charge, the panel is entitled to have regard to its findings set out above and the wider context of what occurred on the night in question. It is apparent that amongst the staff on duty that night, including yourself, there was a systematic practice of completing documentation in advance to give the impression that care had been provided when, in reality, it had not. The purpose was to allow staff, including yourself, to sleep while ostensibly on duty.

Accordingly, the panel is satisfied on the balance of probabilities that when you countersigned the repositioning chart (Exhibit 3, p.25), you knew that the resident had not been repositioned as required.

Having regard to the test set out in the case of *Ivey v Genting* (referred to above), the panel was also satisfied that you knew it was wrong to countersign the entry which would mislead anyone who subsequently examined the notes into believing that the resident had been repositioned as required.

The panel concluded that your action in doing so would be considered dishonest by the standards of ordinary decent people.

Accordingly, the panel found Charge 2b(i) proved.

Charge 2b(ii)

2. Your conduct at charges 1a and/or 1b was dishonest in that you:

    …

    b. Knew care staff:

        i. …

        ii. Had not conducted hourly checks on one or more residents

This charge is found NOT proved.

The panel noted that the wording of Charge 2b(ii) was predicated on the assumption that the hourly checks were the duty of the care staff.

However, the evidence presented to the panel suggested that you yourself would conduct the hourly checks, on some occasions, care staff undertook some of them, and that on certain occasions the checks were carried out jointly. The evidence was unclear as to with whom the responsibility for hourly checks laid.

The panel observed that, when asked about hourly checks during your initial interview with Ms Green, you stated:

> *'*[Ms Green] *But what about the hourly check or the residents who can't use the call bells*
>
> [You] *I don't do the hourly checks, the girls*
>
> [Ms Green] *Ok, so how do you make sure they do this?*
>
> [You] *I go around and do it myself?'*

Your oral evidence when asked about the hourly checks was:

> *'Well I do it, I do it myself…you know who needs hourly checks, the carers check and I do as well, I do myself'*.

This reinforced the lack of clarity as to who bore responsibility for the checks, and, in any event, there was nothing provided to the panel to indicate whether the checks were separately recorded and, if so where and by whom. The only references to anything akin to hourly checks within the residents' daily notes were the entries including the words *'safety checks maintained'*.

In the circumstances, the panel could not be satisfied that, prior to the arrival of Ms Do Carmo Miranda and Ms Clayton on 14 July 2022, hourly checks should have been undertaken by care staff rather than by you. The panel was therefore unable to conclude that there was any responsibility upon the care staff to carry out the checks, and accordingly the charge as drafted could not be found proved.

For completeness, the panel did not consider it necessary or appropriate to amend the charge in the light of the lack of clarity concerning who was responsible for carrying out the hourly checks. Your admission of Charge 1b (as amended) and the panel's finding of dishonesty in relation to Charge 2a properly and sufficiently covered your behaviour regarding the daily notes and the relevant entries you made in them.

Accordingly, the panel found Charge 2b(ii) not proved.

Interim order

The hearing went part-heard prior to the conclusion of the panel's deliberations on facts. As the hearing did not conclude within the five days allocated, and will need to be relisted, the panel considered whether an interim order is required for the period of adjournment. The panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests.

Submissions on interim order

Ms Denholm submitted that the NMC did not intend to make an application for an interim order at this stage.

Mr Bealey submitted that since your referral to the NMC, you have never been subject to an interim order and although you have made admissions to some of the charges, this was evident at the outset of these allegations being made and no restrictions were placed on your practice. He submitted that you have been

practising as a registered nurse since the incident and there have been no concerns raised, no further referrals or disciplinary proceedings against you therefore, you are able to practise without restriction.

Mr Bealey submitted that there is evidence before the panel, by way of testimonials which speak to the good quality of care you provide. He also highlighted that the panel has yet to finalise its findings on facts. Therefore, there is no need to protect members of the public as there is no immediate risk. He further submitted that there is a high bar for an interim order to be met only on public interest grounds and the NMC has not advanced any reason as to why an interim order would be required on this ground. Mr Bealey submitted that being a nurse means everything to you and that it would also not be in your own interest to restrict your practice.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel considered the submissions from both parties and the evidence before it.

The panel considered that you have been working without restriction for the last three years and that no other issues or concerns have been raised about your clinical practice prior to or since this incident. It noted that although admissions have been made, you made these admissions at the outset of the investigation, and you have not had your practice restricted following this. Therefore, there has been no material change in the circumstances of this case at present. This is because at the time of considering the interim order, the panel had not finalised its findings of facts before adjourning. Therefore, it determined that at the time of sitting, there were no identifiable risks of harm.

The panel concluded that an interim order is not necessary on the grounds of public protection. The panel was mindful of the high threshold for imposing an interim order solely on public interest grounds. It did not consider that this threshold was met in this case.

This will be confirmed to you in writing.

That concludes this determination on the facts.

This hearing went part heard on 23 December 2025 and resumed on 6 February 2026.

Interim order

The panel handed down its decision on facts electronically on 23 December 2025, when this hearing went part heard. The hearing resumed on 6 February 2026 for the panel to consider whether an interim order is necessary following the conclusion of the facts stage.

The panel decided to make an interim conditions of practice order for a period of 12 months.

In reaching its decision, the panel considered the documentation before it, together with submissions by Ms Denholm and Mr Bealey. The panel accepted the advice of the legal assessor and took account of the guidance issued by the NMC to panels considering interim orders and the appropriate test as set out at Article 31 of the 'Nursing and Midwifery Order 2001' (the Order). It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests.

Ms Denholm submitted that an interim order is necessary on the grounds of public protection and is otherwise in the public interest. She reminded the panel of the charges that have been found proved, that you were found sleeping whilst on duty, had incorrectly recorded on repositioning charts that repositioning had taken place and the associated dishonesty, and signed resident's notes in advance. She submitted due to these findings there has been a material change in the case and as a consequence there are now identifiable risks of harm. She submitted that your conduct in the charges found proved placed residents at a real risk of serious harm.

Ms Denholm submitted that there have been no further concerns whilst these proceedings have been ongoing however the charges found proved are serious and present identifiable risks. She submitted that these are attitudinal concerns which are difficult to address and relate to basic nursing care. She submitted that your conduct in the charges found proved are a serious departure of the NMC's Code of Conduct and the standards expected of a registered nurse. She submitted that on this basis, the public interest ground is engaged and that if a registrant who has been found to have dishonestly made incorrect entries to patient records, this would bring the profession into disrepute.

Ms Denholm referred the panel to the relevant NMC guidance. She invited the panel to impose an interim suspension order as an interim conditions of practice order would not adequately address the risks which have been identified at this stage.

Mr Bealey submitted that an interim order is not necessary given that your nursing practice has not been restricted since the material incident. He submitted that you have been working with no concerns or issues in that time. He noted that the next stage of this hearing is due to take place in April 2026, just two months away. He addressed the panel on the grounds that an interim order can be made. He submitted the next stage of the NMC hearing is misconduct and impairment, at which further evidence may be provided to show your learning and current fitness to practise. He submitted that the panel must consider your current fitness to practise when considering the imposition of an interim order.

Mr Bealey submitted that the imposition of an interim order is not in your own interest and provided submissions on what the nursing profession means to you. He referred the panel to the references that have been provided throughout the hearing proceedings and also today, which he submitted shows you are a 'good, competent nurse'. He submitted that you were awarded 'Employee of the Month' in December 2025 at your workplace despite the ongoing NMC hearing and that you were the nurse in charge and ensured the Home's continued running over the Christmas

period. He submitted that to restrict your practice or remove you from your current role would be highly reductive and would have an impact on your finances.

In respect of public interest, he submitted that it is a high bar to impose an interim order solely on this ground. He submitted that you have shown that you can practise kindly, safely, competently and effectively. He submitted that you are not currently creating issues that would bring the profession into disrepute.

Mr Bealey addressed the panel with regard to the ground of public protection. He submitted that an order must be necessary not merely desirable based on a very real risk of harm. He submitted that currently there is no proper basis to suggest you pose a risk. He submitted that you have been practising for three and half years since the incident in 2022 without any further concerns. He submitted that you have been fully engaged with these proceedings.

Mr Bealey submitted that if the panel was not with him on his primary submission, it could in the alternative impose an interim conditions of practice order. He submitted that an interim suspension order would be disproportionate and highly reductive.

The panel accepted the advice of the legal assessor.

The panel first considered its findings of fact as set out above. It bore in mind that you have admitted charges 1a and 1b, and that it found charges 1c, 2a and 2b(i) proved.

The panel took into consideration that the facts found proved were directly linked to your clinical practice. It noted the risk of harm to the patients in your care as a result of the conduct found proved. The panel took into account it stated in its findings of fact *"…the panel is entitled to have regard to its findings set out above and the wider context of what occurred on the night in question. It is apparent that amongst the staff on duty that night, including yourself, there was a systematic practice of completing documentation in advance to give the impression that care had been provided when, in reality, it had not. The purpose was to allow staff, including*

yourself, to sleep while ostensibly on duty." The panel noted that you were the sole nurse on charge who allowed this conduct to take place.

The panel was of the view that your conduct involved dishonesty, where you engaged in a systematic practice relating to the charges found proved whereby staff were allowed to sleep on shift and complete inaccurate and misleading records thereby enabling them to do so. The panel therefore was of the view that you appear to have attitudinal issues within your nursing practise.

The panel also noted that your account at the substantive hearing conflicted with the accounts that you had provided contemporaneously at the local investigation. The panel noted that you denied the charges subsequently found proved.

The panel took into consideration that you have not had any concerns or issues regarding your nursing practice since this material incident. It noted the positive references and that you have been awarded 'Employee of the Month' with your employer in December 2025. However, the panel had no information as to your current insight and understanding of the panel's findings on facts. The panel has yet to determine that you have addressed the risks identified in its findings.

Having regard to all of the above, the panel considered that the regulatory concerns are of a serious nature. The panel concluded based on the information before it there is a risk of repetition and a real risk of harm to patients in your care. The panel therefore concluded that some form of interim order is necessary on the ground of public protection.

The panel determined that an interim order is also otherwise in the public interest given that the charges relate to sleeping whilst on duty, completing inaccurate patient records and dishonesty. The panel was of the view that an interim order would maintain public confidence in the profession and declare and uphold proper standards of conduct. Accordingly, the panel concluded that the NMC as your professional regulator and nursing as a profession would be undermined if you were allowed to practise with no restrictions in light of these serious findings.

The panel considered whether to impose an interim conditions of practice order. The panel took into consideration your engagement and that you have been working with no further or similar concerns raised in relation to your nursing practice. In the light of this, the panel decided that there were workable conditions that could be formulated that would mitigate against the risk in the charges found proved.

As such it has determined that the following conditions are proportionate and appropriate:

For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must undertake supervision, meeting weekly with a senior nurse to discuss your record keeping focussed on accuracy and timely recording. You must provide a report of this supervision before the resumption of your hearing.

2. You must limit your nursing practice to working day shifts and not be the sole nurse in charge of any shift.

3. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

4. You must keep the NMC informed about anywhere you are studying by:

a) Telling your case officer within seven days of accepting any course of study.
b) Giving your case officer the name and contact details of the organisation offering that course of study.

5. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any agency you apply to or are registered with for work.
   c) Any employers you apply to for work (at the time of application).
   d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

6. You must tell your case officer, within seven days of your becoming aware of:
   a) Any clinical incident you are involved in.
   b) Any investigation started against you.
   c) Any disciplinary proceedings taken against you.

7. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
   a) Any current or future employer.
   b) Any educational establishment.
   c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The panel took into consideration that the substantive hearing is scheduled to resume in April 2026 to be fully concluded. The panel decided to make this interim order for a period of 12 months in the event that there are delays which cause the

substantive hearing to be delayed. The panel bore in mind that this interim order will cease to have effect once the substantive hearing has been concluded.

Unless your case has already been concluded, this interim order must be reviewed before the end of the next six months and every six months thereafter. Additionally, you or the NMC may ask for the interim order to be reviewed if any new evidence becomes available that may be relevant to the interim order.

At any review the reviewing panel may revoke the interim order or any condition of it, it may confirm the interim order, or vary any condition of it, or it may replace the interim conditions of practice order with an interim suspension order.

The Fitness to Practise Committee is yet to deal with the misconduct, impairment and sanction stages in this case against you. The NMC will keep you informed of developments in relation to your case.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired. The NMC has said:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

The panel, in reaching its decision, recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if

the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, your fitness to practise is currently impaired as a result of that misconduct.

The panel took into account all of the evidence, written and oral, that it has received throughout the hearing to date. The panel heard evidence from you under oath at this stage.

Submissions on misconduct

Ms Denholm submitted that there is no statutory definition of misconduct however, the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 defines it as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Denholm also referred to the case of *Nandi v GMC* [2004] EWHC 2317 (Admin) which emphasizes that the adjective 'serious' must be given its proper weight and in other contexts, has been referred to as conduct which would be regarded as deplorable by fellow practitioners.

Ms Denholm submitted that you had breached the following areas of *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2015) (the Code): Sections 1.2, 1.4, 8.2, 8.3, 8.5, 10.1, 10.2,10.3, 19.1, 20.1, 20.2, 20.3 and 20.8.

Ms Denholm submitted that breaches of the Code do not always amount to misconduct, however it outlines the fundamental requirements of the nursing profession, and breaches of this nature should assist the panel in determining whether the conduct amounts to misconduct.

Ms Denholm outlined the panel's findings on fact and submitted that one of the fundamental aspects of nursing is the provision of safe and effective care and that pre-filling records directly undermines safe practice and the ability to maintain

accurate patient records. She submitted that accurate record-keeping is essential to patient safety and that pre-filling records to indicate that care has been delivered, when it has not, exposes patients to a risk of harm, particularly where vulnerable residents are left unattended while those responsible for their care are asleep.

Ms Denholm submitted that the conduct found proved is serious and that these failings represent clear examples of misconduct, falling far below the standards expected of a registered nurse. They concern basic and fundamental aspects of patient care and professional integrity and such conduct is inexcusable.

Ms Denholm invited the panel to find that that the facts found proved are sufficiently serious to amount to misconduct.

Mr Bealey provided the panel with written submissions and supplemented them with his oral submissions. He submitted that not all breaches of the Code are a regulatory concern and that the conduct found proved must be sufficiently serious to be considered misconduct. He referred to the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin), which emphasises that ‘a single negligent act or omission is less likely to cross the threshold of misconduct than multiple acts and omissions’, although a single act may do so if particularly grave.

Mr Bealey submitted that the panel must assess misconduct only on the basis of the proven facts relating to 14 July 2022 and that any suggestion of behaviour on other nights is ‘unchallengeable hearsay’ and was not put to witnesses during the facts stage. He submitted that it would be unfair to rely on assumptions about unproven events.

Mr Bealey submitted that you have had an otherwise unblemished record. You qualified as a registered nurse in 2007, worked for Bupa from 2011 and you have continued to practise safely at your current employer. He also stated that the panel has references before it, which attest to your competence and professionalism. He submitted that a breach of the Code does not automatically equate to misconduct and that the panel must consider context, seriousness, and proportionality.

Mr Bealey submitted that in these circumstances, the panel may conclude that some or all of the proven charges, arising from a single isolated night, are not deplorable or sufficiently serious enough to amount to misconduct.

Submissions on impairment

Ms Denholm moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. She stated that impairment is a forward-looking exercise and the panel should consider whether your fitness to practise is currently impaired.

Ms Denholm referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and outlined the summary of Dame Janet Smith's 'test' outlined within the 5th Shipman report. She submitted that all four limbs of the *Grant* test are engaged in this case. She submitted that sleeping whilst being the sole nurse on duty and completing inaccurate records, clearly put patients at an unwarranted risk of harm.

Ms Denholm submitted that the public should feel assured that their needs will be met and if they cannot be confident in a registered nurse's ability to complete accurate records, protect patients under their care and be open and honest about care being provided, then this undermines the reputation of the nursing profession. She submitted that your actions have brought the reputation of the nursing profession into disrepute and have breached several sections of the Code.

Ms Denholm referred to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and submitted that the concerns in this case involve clinical failings in record-keeping, sleeping on duty and dishonesty. She submitted that these elements indicate attitudinal concerns, which are inherently more difficult to remediate.

Ms Denholm referred to your bundle, which was previously before the panel and includes training certificates, your CV, testimonials and reflections. She also referred to an email from your employer in which they state that there have been no concerns with your practice. However, Ms Denholm submitted that this does not address the record-keeping concerns identified in this case. There is no evidence before the panel of the weekly supervision meetings required under your interim conditions of practice order. Ms Denholm stated that it is not suggested that these meetings did not occur, but there is no documentation to demonstrate what was discussed or how the concerns, namely the accuracy of recordkeeping, have been addressed. She submitted that this strongly indicates that the concerns have not yet been remedied.

Ms Denholm referred to a supervision record which was completed prior to the imposition of the interim order and submitted that although it made a generic reference to recordkeeping on the new computerised system for all staff, this does not directly address the record-keeping concerns in this case, nor does it link the issues in your own practice. Therefore, it provides limited assistance in determining remediation.

Ms Denholm submitted that in the absence of reflective pieces or supervision records addressing the concerns of sleeping on duty and dishonest record-keeping, your misconduct has not been remedied.

With respect to risk of repetition, Ms Denholm outlined that in your evidence, you stated that in your current role, you use a computerised system and therefore the misconduct could not happen again. However, she submitted that in the future, you may work in settings without this system and given the lack of compliance with Condition 1, the absence of evidence addressing the record-keeping concerns and the limited information before the panel today, there remains a risk of repetition.

In relation to insight, Ms Denholm submitted that it is for the panel to determine whether you have demonstrated sufficient insight in light of the evidence before it. She submitted that based on all the information before the panel, a finding of current impairment is required both to protect the public and to uphold proper professional

standards. Therefore, Ms Denholm invited the panel to find that your fitness to practice is currently impaired.

Mr Bealey submitted that the panel should only consider impairment if misconduct is found and that a finding of misconduct already marks the behaviour as unacceptable to the profession. He submitted that in its consideration of whether your fitness to practise is impaired, the panel must only assess you as you appear today, not in July 2022, and must reflect the body of work done, the efforts made, and the training you have done and good reviews you have had since.

Mr Bealey submitted that you have demonstrated reflection, insight, and remediation and have accepted your mistakes, especially during your oral evidence. He stated that you have undertaken relevant reading, discussed NMC guidance with your manager and adapted your practice. He submitted that there has been no repetition of the conduct in the four years since the incident and your current manager, who has supervised you for the past seven months has raised no concerns with your practice.

Mr Bealey submitted that you have complied with digital record-keeping systems, in which all entries are visible to colleagues and management, and no inaccuracies have been identified. He submitted that your current workplace mitigates the risk factors that were present in 2022 and that you now take your breaks in appropriate areas, where you remain visible to colleagues and residents and you use this time to update residents' records. He submitted that these changes have now become embedded habits in your nursing practice.

Mr Bealey submitted that your long, unblemished career, positive references and the evidence of colleagues demonstrate that the events of 14 July 2022, were out of character. He submitted that your manager has confirmed that she would trust you to work unsupervised on night shifts and lead a team and you have been described as a 'good and safe nurse', which speaks strongly of your current practice and competence.

Mr Bealey submitted that you have continued to work despite personal hardship, including bereavement and you have shown dedication to your role as a registered nurse, including working on Christmas Day, attended hearings, and maintaining standards. He submitted that you were presented with an ‘Employee of the Month’ award in December while working night shifts. Mr Bealey submitted that this further demonstrates that the concerns have been addressed, remediation has taken place, and repetition is highly unlikely.

Mr Bealey submitted that you maintain that you have complied with Condition 1 of your interim order and that the NMC does not dispute that the supervision meetings occurred. The issue relates only to the fact that there is an absence of written records of these meetings from your manager and you have made efforts such as making phone calls, sending emails and even going to your workplace to try and obtain this for the panel. He submitted that your manager confirms your compliance with the interim order and there are no issues with your record-keeping.

Mr Bealey submitted that the purpose of Condition 1 was to ensure accurate record-keeping and understanding of professional standards and this purpose has been achieved, given your evidence, training and practice.

Mr Bealey submitted that the public interest is already upheld by any finding of misconduct, which signals clearly that such behaviour is unacceptable. He submitted that a fully informed member of the public, aware of your insight, remediation, four years of safe practice and strong employer support, would not be concerned by a finding of no current impairment. He submitted that you have demonstrated safe practice, completed training, maintained accurate records and worked effectively within a team and your ‘Employee of the Month’ demonstrates sustained quality.

Mr Bealey therefore invited the panel to find that your fitness to practise is not currently impaired.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that your actions amounted to a breach of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *…*
> ***1.2** make sure you deliver the fundamentals of care effectively*
> *…*
> ***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
> *…*
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *To achieve this, you must:*
>
> ***3.1** pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
> *…*
> ***8 Work cooperatively***
> *To achieve this, you must:*
> *…*
> ***8.2** maintain effective communication with colleagues*
> ***8.3** keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
> *…*
> ***8.5** work with colleagues to preserve the safety of those receiving care*
> *…*
> ***10 Keep clear and accurate records relevant to your practice***

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

***10.1** complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
***10.2** identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
***10.3** complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
…
19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:
***19.1** take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*
***19.2** take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)*
…
"Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety"

20 Uphold the reputation of your profession at all times
To achieve this, you must:
***20.1** keep to and uphold the standards and values set out in the Code*
***20.2** act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
***20.3** be aware at all times of how your behaviour can affect and influence the behaviour of other people'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel findings were that your conduct, on 14 July 2022, of engaging in a systematic practice of completing documentation in advance to give the impression that care had been provided when, in reality, it had not, was dishonest. The panel noted that the purpose was to allow staff, including yourself, to sleep while on duty, which put vulnerable residents at an unwarranted risk of harm. The panel considered that you were an experienced nurse, who was the sole nurse in charge and responsible for the care of vulnerable residents and that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct, which was serious.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (*DMA-1*), last updated on 28 January 2026, in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel concluded that all four limbs of the *Grant* test were engaged in this case. The panel found that your dishonest conduct of engaging in a systematic practice of falsifying records to enable yourself and colleagues to sleep on duty, put a number of

vulnerable residents at an unwarranted risk of harm. The panel considered that your misconduct had breached the fundamental tenets of the nursing profession, including honesty and integrity, and that you had also breached parts of the Code, therefore bringing its reputation into disrepute.

The panel was aware that this is a forward-looking exercise and went on to consider current impairment. The panel had regard to the case of *Cohen,* which outlines the following:

1. Can the conduct be remediated?
2. Whether the concern has been addressed
3. Whether it is highly unlikely that the conduct will be repeated

The panel considered that concerns relating to dishonesty are often more difficult to remediate, as dishonesty is an attitudinal failing. Nonetheless, it considered that your misconduct and dishonesty could be remediated through significant reflection, insight, training targeted at the specific areas of concern and strengthened practice. The panel considered your oral evidence, the positive references provided from your employer, former colleagues and members of the public, your unblemished nursing career before and after these events, your reflections in your witness statement provided at the facts stage and your training certificates.

The panel acknowledged that you have expressed remorse for your actions and have demonstrated developing insight and some understanding into your actions and their impact on residents, their families, your colleagues, the wider public and the reputation of the nursing profession. The panel also recognised that before this incident and for nearly two years out of the four since, you have worked as a registered nurse, with no new concerns raised about your practice or conduct.

Notwithstanding this, the panel took into account that you have not provided any further evidence since the panel's findings on the facts of your insight into the seriousness of your dishonest conduct, such as an in-depth reflective piece focused on the findings or evidence to demonstrate targeted learning, despite having ample time to do so.

As part of the panel's evaluation of insight, reflection and remediation demonstrated by you, it had regard to your interim conditions of practice order, imposed after the panel had made its findings on facts. In particular, the panel considered the extent of your compliance with Condition 1, as set out below:

> *'You must undertake supervision, meeting weekly with a senior nurse to discuss your record keeping focussed on accuracy and timely recording. You must provide a report of this supervision before the resumption of your hearing.'*

The panel was of the view that Condition 1 was very clear in what was expected of you, and that the onus was on you to have complied with it. Whilst sympathetic towards the difficulties it appears you have had with your employers, the panel considered that if there were issues at work leading to you not being able to comply with a condition imposed to protect the public, you should have alerted the NMC to that. In fact, no mention at all was made of the report specifically asked for in Condition 1 before resumption of this hearing, until it was raised as an issue by the panel itself. The panel was of the view that in not providing the report, you had not complied with Condition 1.

The panel balanced fairness to you with the expeditious disposal of the hearing and allowed a significant period of time during the hearing, for you to liaise with your employers in order to obtain the report which would have evidenced compliance with Condition 1.

Unfortunately, that report has not been received. The panel however, took into account the information in the form of two letters and an email, from your employer, about your practice in general terms, and your overall compliance, in their view, with the interim order of conditions. The panel was of the view that this information was useful, albeit generic, but that it did not evidence weekly supervision discussions with a senior nurse focussed on accurate and timely record keeping.

The panel concluded that in not ensuring you were fully complying with Condition 1, you have shown a lack of understanding of the seriousness of the dishonest and inaccurate record keeping findings against you. You should have been aware that the interim order of conditions was imposed to protect the public, in light of the panel's findings. Complying with the condition would have afforded you a clear opportunity to demonstrate both your understanding of the seriousness of your misconduct, and how your practise had developed or changed as a result of your understanding.

The panel also acknowledged that you are entitled to defend allegations made against you and must have a fair opportunity to do so. The panel took into account that you had denied the primary fact of sleeping whilst on duty, and the secondary allegations of acting dishonestly because you signed resident's records that contained incorrect information and knew care staff had not repositioned one or more residents. The panel has found these denied facts proved.

The panel was of the view that you have shown some insight in a general sense, into the risks of sleeping whilst on duty and of signing off inaccurate records dishonestly. It did not count your denials of these charges against you. However, it did consider that your oral evidence in relation to your acceptance of the panel's findings on the elements of sleeping on duty and acting dishonestly to be contradictory and confusing.

You said that you accepted the panel's findings but went on to say that you had never, and would never, sleep whilst on duty, but stated later that sleeping on duty 'will not repeat itself'. In answer to panel questions on your reflections on dishonesty, you gave generalised answers about having learnt lessons that you should not do that and that in your current role there is no paperwork as the system was digital. When you were asked how you would behave differently, you told the panel you respect the residents, adhere to the NMC code and that you were more aware of the residents you were looking after. Overall, and taking into account that it is not always easy to articulate concepts such as insight when giving evidence, the panel

concluded that you were only able to demonstrate a surface level understanding of the seriousness of the matters found proved against you.

The panel was of the view that the list of training provided only addressed some of the concerns in this case and the certificates were generic and untargeted to the specific concerns in this case. The panel therefore concluded that the training that you have undertaken is insufficient to demonstrate meaningful remediation of the concerns.

The panel acknowledged that you are currently working in a different environment with robust electronic record-keeping systems and you are not the sole nurse in charge. However, due to the seriousness of your misconduct, your insufficient insight and lack of targeted learning, the panel concluded that there is a likelihood of repetition. There remains a real risk of serious harm to the public. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel took into account the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is also required. You are an experienced nurse, who was the sole nurse on duty and responsible for the care of vulnerable residents and engaged in the falsification of records to give the impression that care had been given, when it had not, in order to allow staff, including yourself, to sleep on duty. The panel was of the view that a well-informed and reasonable member of the public, appraised of all the facts, would be deeply concerned by the circumstances of this case and that public confidence in the nursing profession would be undermined if a finding of impairment was not made. The panel therefore finds your fitness to practise is impaired on the grounds of the public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel considered this case very carefully and decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck off the register.

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (References: SAN-1, SAN-2a-e, SAN-3 and SAN-4).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Denholm informed the panel that in the Notice of Hearing, dated 14 October 2025, the NMC had advised you and your representative that it would seek the imposition of a striking-off order if the panel found your fitness to practise to be currently impaired. However, she submitted that the panel should consider all the sanctions available to it, in light of the documents it has received prior to today.

Ms Denholm referred to the panel's previous decisions with respect to misconduct and impairment. She submitted that the panel has been provided with a certificate of your completed course 'Team Leaders and Managers – Person Centred Practices' dated 12 May 2026, together with supervision records and development and support meeting forms relevant to your compliance with Condition 1 of your interim conditions of practice order, dated between January to June 2026. She submitted that these documents indicate positive practice, with no issues raised by your employer and no concerns identified in relation to your practice.

However, Ms Denholm invited the panel to note that you still have not provided a reflective piece addressing the concerns found proved, including the impact of your conduct on your colleagues, residents and the wider public. She referred the panel to the sanctions guidance which asks panels to ensure that any sanction that is imposed is proportionate and balances a registrant's rights with the NMC's overarching objective of protecting the public, maintaining professional standards and upholding public confidence.

Ms Denholm submitted that an aggravating feature in this case is that there was a risk of harm to residents, particularly as you were the sole nurse on duty at the time. She submitted that the mitigating features include that the incident was limited to one evening, your admissions to Charges 1a and 1b from the outset and that you have shown remorse.

Ms Denholm then invited the panel to consider each sanction in order of severity. She submitted that taking no action or imposing a caution order would be insufficient given the seriousness of the conduct, the risk of harm and the public interest concerns identified at the impairment stage. She submitted that a conditions of practice order would be inappropriate because the concerns in this case are related to attitudinal concerns rather than clinical issues and there remains insufficient insight into your conduct, the risks to residents and the wider impact on the profession.

Ms Denholm submitted that a period of suspension, with a review, would be proportionate, as it would protect the public and allow you to return to practice only once sufficient insight and remediation have been demonstrated. She submitted that the panel may also take into account that you have complied with conditions for a period of nine months and that you had not been subject to any restriction during the earlier investigation period.

Ms Denholm submitted that ultimately, the panel is invited to exercise its independent judgment and consider whether the seriousness of the falsification of

records and sleeping on duty, in the absence of full reflection and insight, means that striking off is proportionate, while also taking into account your personal circumstances and previously unblemished nursing career.

Mr Bealey provided the panel with his written submissions and submitted that any sanction imposed by the panel should be the least restrictive measure capable of protecting the public, given the panel's findings and the interim conditions of practice order already in place. On that basis, he submitted that a caution or conditions of practice order would be the most proportionate response to the risks identified in your conduct.

Mr Bealey submitted that you have demonstrated remorse, admitted most of the charges and have accepted the facts. He submitted that the incident occurred in 2022, nearly four and a half years ago, and since then, you have worked, both with and without restrictions, without any repetition of the behaviour. He submitted that references and documentation before the panel show that you currently meet the required standards, have received awards for your work and have consistently achieved full compliance with training requirements, including 100% completion on the Hippo system. He further submitted that you have undertaken relevant courses and provided reflection, albeit limited, but nonetheless indicative of learning and an understanding of the seriousness of the concerns.

Mr Bealey submitted that your evidence showed that you appreciate the consequences of your actions for colleagues, patients and public trust. He submitted that nursing has been your chosen career for 20 years and you have worked to regain trust, as reflected in supervision reports confirming high standards of care, timely and accurate record-keeping and no concerns raised by colleagues overseeing your work.

Mr Bealey submitted that the incident was isolated and was not part of a pattern. He submitted that your current employer, having been aware of your NMC referral, would have been alert to any recurrence and none has arisen. He submitted that

your safe practice over the past four and a half years significantly reduces any inference of ongoing risk.

Mr Bealey submitted that the panel has already recognised that you have demonstrated some insight and remediation. He submitted that insight is an evolving process and the documentation shows that you continue to apply learning, remove errors and maintain professional standards. He submitted that your ability to practise throughout the proceedings, although recently under restrictions, demonstrates that public confidence does not require your removal from practice. He further submitted that you have engaged fully with the process, attending hearings, answered difficult questions and shown emotional investment in addressing the concerns raised.

Mr Bealey submitted that you have personal mitigation, in that you have [PRIVATE], which you have managed without complaint throughout a demanding 20-year career. He submitted that nursing is your passion and the proceedings have had a significant personal impact on you. He submitted that a removal from practice would be [PRIVATE] devastating and, given your age, would make career change extremely difficult. He submitted that sanctions are not intended to be punitive and personal mitigation must be weighed appropriately.

Mr Bealey submitted that the interim conditions of practice order imposed in February 2026 has severely limited your ability to work because direct supervision is rarely available in your employer's care home setting. He submitted that this has caused substantial financial and personal hardship for you. He submitted that you have complied fully, even ceasing work entirely when shifts could not meet the conditions. He submitted that the supervision records reflect only the limited shifts you have been able to obtain and you have persevered despite these obstacles, demonstrating commitment to compliance.

Mr Bealey submitted that a caution order or a conditions of practice order are the most appropriate sanctions in this case. He submitted that a caution order would mark the misconduct, reflect the panel's finding of impairment and remain on your record for years, effectively marking the remainder of your career. He submitted that

this would be justified because the incident was isolated, you have shown insight and your current working environment includes robust safeguards that make recurrence unlikely.

Mr Bealey submitted that if a caution is deemed insufficient, a conditions of practice order would address any remaining concerns. He submitted that you have already complied with an interim conditions of practice order, showing that you would adhere to a substantive one. He submitted that the panel could impose the same conditions or modify them to allow indirect supervision, enabling you to work more consistently while still ensuring oversight. He submitted that additional conditions could include regular reading logs or reflective submissions to support your ongoing development.

Mr Bealey submitted that a suspension order or a striking-off order would be disproportionate, as you have shown insight, engaged with the process and maintained safe practice for over four years. He submitted that removal from practice would destabilise your life, undermine your [PRIVATE] and would also sacrifice the career of an otherwise competent nurse with no prior regulatory concerns.

Mr Bealey submitted that you have dedicated 20 years to nursing and you understand the gravity of the proceedings. He submitted that you have demonstrated through four years of safe practice that you can meet the standards expected of you. He submitted that a caution order or a conditions of practice would allow you to continue contributing to the profession while addressing the panel's concerns.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a position of trust as an experienced Nurse in Charge and sole nurse on duty
- Conduct which deliberately put vulnerable people receiving care at direct risk of suffering harm
- Deliberate breaches of the Code
- Attitudinal issues towards professionalism
- Dishonest conduct engaging in premeditated behaviour in your systematic practice of completing documentation in advance to allow yourself and others to sleep whilst on duty
- Insufficient insight

The panel also took into account the following mitigating features:

- Early admissions to some of the facts
- Previous unblemished nursing career of 20 years
- Demonstration of some remorse
- Evidence that you have worked safely and professionally in your role as a registered nurse since the events causing concern
- Some evidence of training evidenced by certificates, although the panel noted that this was not targeted and does not fully address the issues raised in this case.
- No repeated incidents since the original concerns

The panel had regard to NMC sanction guidance *SAN-4* and noted that, although your dishonesty was found proved in relation to one shift and against the background of a long and otherwise unblemished career, it was particularly serious. The panel considered that you had engaged in a systematic practice of completing documentation in advance to give the impression that care had been provided when, in reality, it had not, which was dishonest. The panel noted that the purpose was to allow staff, including yourself, to sleep while on duty, which put vulnerable residents

at an unwarranted risk of harm. The panel considered that you were an experienced nurse, who was the sole nurse in charge and responsible for the care of vulnerable residents and this placed your misconduct at the higher end of the spectrum of dishonesty.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that your actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel noted the submissions of Mr Bealey however, it determined that a sanction that does not restrict your practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on your registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026). The panel was of the view that there are no relevant, proportionate, workable or measurable conditions that could be formulated. The panel noted that the recordkeeping concerns in this case could be remedied. However, given the attitudinal nature and the seriousness of your dishonesty and your limited insight and reflection on the impact of your actions on

residents and the reputation of the nursing profession, it determined that this was not something that could be addressed through conditions. Furthermore, the panel concluded that placing conditions on your registration would not adequately mark the seriousness of this case, protect patients or uphold professional standards.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which*

evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'

Whilst the panel acknowledged that the risks identified could be managed by you being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. The panel had regard to the guidance at *SAN-3* 'Deciding between suspension and strike off' and placed weight on the significant aggravating features it has identified. The finding of dishonesty, your insight and the ongoing risk of harm.

Given the level of seriousness of the concerns in this case and the panel's findings on impairment and that it still did not have evidence of sufficient insight. The panel noted that in the five months since giving you its detailed reasons on impairment, you have not provided further reflection or evidence of full insight into the attitudinal concerns, or into the severity and seriousness of your misconduct. Given your limited insight, limited demonstration of remorse, together with no evidence of targeted training on the importance of accurate record keeping, the panel considered that there is no realistic possibility that you would address the concerns to such a level where you could return to practise safely.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering dishonesty, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). The panel determined that your conduct was a direct risk to vulnerable patients receiving care and was premeditated and systematic. The guidance points to these forms of dishonesty as being most likely to require consideration of a striking-off order.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel considered that your conduct was systematic and falsifying records enabled yourself, as well as other members of staff, to sleep while on duty, which would have placed vulnerable patients at risk of harm. The panel remains concerned about the seriousness of the conduct, the finding of dishonesty and the limited evidence of meaningful insight or remediation.

The panel concluded that you have demonstrated only a surface-level understanding of the seriousness of the matters found proved against you. The panel acknowledged that you have provided training certificates however, it noted that the training did not specifically address the key concerns in this case, including the importance of accurate record keeping and it considered that the training provided was insufficient to demonstrate meaningful remediation. Since receiving the reasons on facts, misconduct and impairment, you have had sufficient time to provide further evidence demonstrating the development of full insight into the seriousness of the matters in this case, including how you would act differently in the future. The panel had not received such evidence, such as a reflective account demonstrating a full understanding of, and insight into, the impact of your conduct on patient safety, your colleagues and public confidence in the profession.

Your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate your

actions were serious and to allow you to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themself, the panel concluded that nothing short of this would be sufficient in this case.

In considering the principle of proportionality, the panel recognised and took into account the impact a striking off order will have on you and the personal mitigating features it has found. However, the panel considered that this order was necessary to protect the public and to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to you in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Denholm. She invited the panel to impose an interim suspension order for a period of 18 months on the

grounds of public protection and otherwise in the public interest. She submitted that as the striking-off order will not take effect until after a 28-day appeal period, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

Mr Bealey invited the panel to impose an interim conditions of practice order, in the same terms as your current interim conditions of practice order. He submitted that imposing an interim order does not automatically follow the imposition of a sanction.

Mr Bealey submitted that imposing an interim conditions of practice order would enable you to continue earning an income during a transitional period and would also give you the opportunity to begin planning and developing towards a new career or future options. He submitted that if an interim suspension order were imposed, you would have no immediate means of income for the foreseeable future while you attempt to secure alternative employment.

Mr Bealey submitted that up until today, you have been permitted to work and although the panel has now made a substantive decision, the practical reality of your ability to practise today is no different from tomorrow. The only change is the panel's decision itself.

Mr Bealey submitted that these proceedings have taken an immense toll on you over the past four years and you have had to repeatedly justify poor decision-making from 2022 and have found it distressing that your 20-year nursing career has not been fully recognised or appreciated at its conclusion, despite an otherwise positive professional history.

Mr Bealey submitted that you have practised for the past seven months without restrictions and without concerns being raised. He submitted that it is therefore entirely possible for you to continue to practise safely during a short transitional period under an interim conditions of practice order. He submitted that any interim order would remain subject to review and would fall away upon the conclusion of the

appeal period, but it would provide you with essential time to adjust to what will inevitably be a future without nursing.

Balancing the relevant factors, Mr Bealey submitted that an interim conditions of practice order would meet the concerns identified by the panel while supporting your ability to manage the immediate practical consequences of the decision.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the sanction it has imposed; namely a striking-off order and the reasons for that, and its findings and reasons on the facts, misconduct and impairment.

The panel took into account Mr Bealey's submissions. However, the panel determined that in view of its findings and reasons overall, only an interim suspension order would be consistent with its determination. This would be a proportionate response in the view of this panel. The panel determined that, in imposing an interim suspension order, the public would have the continuity of protection from harm, and the public interest would continue to be upheld. In the panel's judgement, these factors outweigh your own interests during the potential appeal period or the 28-day notice period.

The panel has therefore determined to impose an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim suspension order will be replaced by the substantive striking-off order 28 days after you have been sent the decision of this hearing in writing.

That concludes this determination.